1100 INTRODUCTION

The Nevada Medicaid Ocular program reimburses for medically necessary ocular services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Support Services at Nevada Medicaid.

Ocular services are an optional benefit within the Nevada Medicaid Program.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

1101 AUTHORITY

The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulation, (CFR) Part 440.200, and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Social Security Act. CFR 440.225 and 441.30. New State Plan, Section 3.1 page 19, 216 and 27

The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

Physicians: NRS Chapter 630.375
Optometry: NRS Chapter 636
Dispensing Opticians: NRS Chapter 637

1102 DEFINITIONS

1102.1 LEGAL BLINDNESS

Legal blindness is defined in state law as:

a. Visual acuity with correcting lenses of worse than 20/200 in the better eye; or

b. Field of vision subtending an angle of less than 20 degrees in the better eye.

1102.2 OCULAR SERVICES

Ocular services include refractive examinations with a prescription for corrective lenses, and fitting and provision of corrective lenses. The medical diagnostic examination of the eyes performed by an ophthalmologist is not considered an ocular service, rather it is a physician's service discussed in Chapter 600 of the Medicaid Services Manual.

1102.3 OCULARIST

Ocularist refers to a person skilled in measuring, fitting, and dispensing prosthetic eyes.

1102.4 OPHTHALMOLOGIST

Ophthalmologist refers to a physician, licensed by the state in which he/she practices, who limits his/her practice to the science dealing with the structure, functions, and diseases of the eye. In addition to the use of medication and surgical techniques, the provider may prescribe optical instruments and corrective lenses, and may or may not dispense such items.

1102.5 OPTICIAN

Optician refers to a person licensed by the state in which the provider operates as a maker or dealer in optical items and instruments (to include spectacle lenses) and who may construct such items and instruments to prescription. The provider does not perform ocular examinations, but may dispense optical aids to the patient.

1102.6 OPTOMETRIST

Optometrists are licensed by the state and skilled in the art and science of examining the eye for visual defects or faults of refraction and in prescribing, fitting, and adapting corrective lenses and/or exercises to correct such faults or defects. Optometrists may construct correctional eyeglasses and dispense such aids. The optometrist may also prescribe or direct the use of pharmaceutical agents to treat an abnormality of the eye or its appendages; remove a foreign object from the eye; or order laboratory tests to assist in the diagnosis of an abnormality of the eye or its appendage.

1103 POLICY

1103.1 OCULAR SERVICES

1103.1A COVERAGE AND LIMITATIONS

Medicaid will reimburse for routine comprehensive ophthalmological examinations and/or refractive examinations of the eyes and glasses with a prescription for and provision of corrective eyeglasses to eligible Medicaid recipients once every twelve (12) months. Any exceptions require prior authorization.

1. HEALTHY KIDS (EPSDT)

   a. Nevada Medicaid provides for vision screenings as referred by any appropriate health, developmental, or educational professional after a Healthy Kids Screening Exam. Optometrists and ophthalmologists may perform such exams without prior authorization upon request or identification of medical need. "Medical Need" may be identified as any ophthalmological examination performed to diagnose, treat, or follow any ophthalmological condition that has been identified during the Healthy Kids examination.

   b. Glasses may be provided at any interval without prior authorization for EPSDT recipients, as long as there is a change in refractive status from the most recent exam, or for broken or lost glasses. Physician records must reflect this change and the records must be available for review for the time mandated by the federal government. Recipients enrolled in a Managed Care plan are mandated to access Healthy Kids (EPSDT) ocular services through their Managed Care provider.

2. EXAMINATIONS

   a. Recipients requiring a refractive exam performed by an optometrist for a medical reason (e.g., conjunctivitis, glaucoma examination) do not require a prior authorization to receive services. Medical diagnosis ICD-9 codes must substantiate the service.

   b. A recipient requiring a detailed/comprehensive glaucoma work-up and/or diagnostic examination does require prior authorization.

   c. Refractive examinations performed by an opthalmologist for medical needs are considered a regular physician visit. Current limitations are based on medical necessity and do not require prior authorization.

   d. Routine ocular examinations (and purchase of eyeglasses) are limited to one exam/set of glasses per 12-month period.

The following are not limited to the 12-month restriction on examination and lenses:

1. Following cataract surgery, all requests for eyeglasses must be prior authorized by forwarding an outpatient prior authorization form to the QIO-like vendor. The date of surgery and documentation of refractive changes must be attached to the request.

   If the recipient is Medicare eligible prior authorization is not required. The provider must bill Medicare first and attach a Medicare EOB to the claim for co-insurance and deductible.

2. Glaucoma

3. Diabetes

4. Healthy Kids/EPSDT referral services

3. LENSES

Lenses must be prior authorized by the QIO-like vendor for recipients over 21 years of age, if the last request was less than 12 months earlier. Medicaid documentation, diagnosis and ICD-9 codes must substantiate the request.

a. COVERED

The following are covered as noted:

1. A change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within the twelve (12) month limitation;
2. Lens material may be tempered glass tillyer grade or equivalent, or standard plastic, at recipient's option;
3. Ultra lightweight plastics, e.g., Lite Style and polycarbonate-style, are covered when they are medically necessary to avoid very heavy glasses which would hurt the bridge of the nose. The acceptable means for avoiding severe imbalance of the weight of the glasses are up to $\pm$7 diopters in children and $\pm$9 diopters in adults;
4. Polycarbonate lenses are covered under EPSDT when medically necessary.
5. Safety lenses when the recipient has vision in only one eye;
6. A single plano or balance lens is handled as if it were a corrective lens, and so called "half glasses" are handled as if they were standard size corrective lenses;

7. Slab-off lenses, Prisms, Aspheric, Lenticular lenses;
8. "Executive" bifocals may be covered for children with: esotropia, and esophoria, accommodation, oculomotor dysfunction such as tracking and saccadic problems. Prior authorization is not required when using one of the above medical diagnoses;
9. Filters: PLS 40 filters when prescribed for patients with the following diagnoses: macular degeneration, retinitis pigmentosa, rod/cone dystrophy, or achromastopia. In all these cases, the best uncorrected vision must test better than 20/200;
10. UV filters when prescribed following cataract surgery;
11. Bifocals and trifocals are reimbursable for a combination of any of the conditions at near or far point, including but not limited to: estropia, esophoria, cataracts, glaucoma, accommodative dysfunctions, nystogmus, stigmatism, myopia, presbyopia;
12. Double segment lenses required for employment;
13. Therapeutic contact lenses when prescribed for treatment of a medical condition;
14. Tints are covered when medically necessary;
15. Low vision aides such as telescopic lenses, magnifying glasses, bioptic systems and special inserts in regular lenses.
16. Scratch-proof coatings for plastic lenses are covered for EPSDT recipients.

b. NON-COVERED

The following are not covered:

1. Sunglasses and cosmetic lenses.

2. Contact lenses are disallowed UNLESS their use is:

   a. The only means to bring vision to the minimum criteria required to avoid legal blindness; or

   b. Medically indicated following cataract surgery; or

   c. The necessary means for avoiding very heavy glasses which would hurt the bridge of the nose (e.g., where the correction is 9+ diopters in each eye). The necessary means for avoiding severe imbalance of the weight of glasses is where one eye is corrected to 9+ diopters and the other eye is 3+; or

   d. Required when the recipient has a diagnosis of Keratoconus.

3. Replacement of lenses, unless the patient has a significant change in refractive status.

4. Blended and progressive multi-focal lenses, “transitional lenses”.

5. Faceted lenses.

6. “Additional” Cost of an Extended Repair, Replacement warranty (ERR).

4. FRAMES

a. COVERED

The following are covered:

1. Existing frames must be used whenever possible. If new frames are necessary, they may be metal or plastic, at the patient's option, up to Medicaid’s allowable cost.

2. Providers must stock a variety of frames to enable the recipient to choose a frame at no cost to them, if they so choose.

b. NON-COVERED

The following are not covered:

1. Frames with ornamentation.

2. Eyeglass frames which attach to or act as a holder for hearing aid(s).

5. OCULAR PROSTHESIS

Ocular prosthesis are a covered Medicaid benefit and must be prior authorized. The prescribing physician must forward the PA to the QIO-like vendor for authorization.

6. VISION THERAPY

Vision therapy is a covered Medicaid benefit and must be prior authorized by the QIO-like vendor.

1103.1B PROVIDER RESPONSIBILITY

1. Providers must confirm the recipient's eligibility by reviewing the current Medicaid card before providing services, or access eligibility via the Electronic Verification of Eligibility (EVE) system.

2. It is the provider's responsibility to ask the recipient if there is additional visual coverage through third party payers.

1103.1C RECIPIENT RESPONSIBILITY

Services requested by the recipient but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid such as: eyeglass extras and non-covered filters. Prior to service, the recipient must be informed in writing and agree in writing he/she will be responsible for payment.

1. The recipient is responsible for presenting a valid Medicaid card to the examiner and/or optician.

2. The recipient is responsible for presenting any form or identification necessary to utilize other health insurance coverage.

3. If the recipient selects a frame with a wholesale cost greater than the Medicaid allowable, they will be responsible for the additional amount. The recipient's agreement to make payment must be in writing. A copy of the agreement must be retained in the recipient's chart. The Nevada Medicaid Surveillance and Utilization Review Unit (SURS) conducts a regular review of claims history to monitor this.

4. If the recipient selects a lens options not covered by Medicaid, he/she is then responsible for payment only of the non-covered options. Medicaid pays the lens cost minus the cost of options. Non-covered options must be listed separately on the invoice. Claims will be returned to providers for correction.

5. If the recipient chooses an Extended Repair Replacement warranty (ERR) which is not covered by Medicaid's payment, he/she is responsible for warranty payment.

6. The recipient is responsible for making and keeping appointments with the doctor.

7. The recipient is responsible for contacting the provider of the eyeglasses (if different from the examiner) for fitting and delivery.

8. The recipient is responsible for picking up the eyeglasses and returning for any necessary adjustments within the time allotted for such adjustments. (Medicaid will not pay for office visits for adjustments. The provider is expected to make reasonable adjustments and repair, without charge).

9. The recipient is responsible to inform the provider if they have had a routine exam or eyeglasses in less than the allotted time. Providers may request that recipients sign a form accepting responsibility for payment of any routine eyeglasses or exams that are provided before the12 month period.

1103.1D AUTHORIZATION PROCESS

1. UNCLAIMED EYEGLASSES

All services must be prior authorized unless otherwise noted. The recipient has 15 days to claim eyeglasses reimbursed by Nevada Medicaid. If after 15 days the item is still held by the provider:

a. The provider shall notify the appropriate district office.

b. The caseworker attempts to contact the recipient and make arrangements to claim the eyeglasses.

If the caseworker is unable to contact the recipient or the recipient refuses to claim the eyeglasses, the worker advises the Nevada Medicaid Office (NMO) and notifies the provider the item will not be picked up. NMO then notifies Utilization Control for a possible restriction of the recipient's medical services.

c. Following notification the item will remain unclaimed, provider may submit a bill in the normal fashion to the Nevada Medicaid fiscal agent.

1104 HEARINGS

Please reference Nevada Medicaid Services Manual Chapter 3100, for Medicaid Recipient Hearings process.

1105 REFERENCES AND CROSS-REFERENCES

a. Other sources which impact the provision of Ocular Services include but are not limited to the following:

MEDICAID SERVICES MANUAL

Chapter 100 Eligibility, Coverage and Limitations
Chapter 600 Physician Services
Chapter 1300 DME, Prosthetics, and Disposable Supplies
Chapter 1500 Healthy Kids / EPSDT
Chapter 1900 Medical Transportation
Chapter 3100 Medicaid Recipient Hearings
Chapter 3300 Surveillance and Utilization Review Section (SURS)
Chapter 3400 Residential Treatment Center (RTC) Services
Chapter 3600 Managed Care Organization
Chapter 3700 Nevada Check Up

1105.1 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS
Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS
First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
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PHARMACY POINT-OF-SALE DEPARTMENT
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Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
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